General Information

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Your Insurance Benefits:

Help When You Need It Most

Your insurance, offered through the Employee Insurance Program, provides a financial safety net when you are ill or injured. Several health plans are available. Through the **State Health Plan**, you may enroll in the Standard Plan or the Savings Plan.

Three **Health Maintenance Organizations** are offered:
- BlueChoice HealthPlan is available statewide.
- CIGNA is available in all counties **except** Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda.
- MUSC Options is available in Berkeley, Charleston, Colleton and Dorchester counties.

For a list of retiree health insurance options, including the Medicare Supplemental Plan, please refer to the Retirees chapter on page 137.

The **TRICARE Supplement** is available to those enrolled in TRICARE, the Department of Defense's health insurance program for the military. For eligibility requirements, see page 61.

Eligible subscribers also may enroll in the State Dental Plan and in Dental Plus, which pays a higher amount for the same services except orthodontia.

Active employees who enroll in a health plan receive Basic Life Insurance and Basic Long Term Disability Insurance at no charge.

ENROLLING IN A HEALTH OR DENTAL PLAN

Initial Enrollment

If you are an eligible employee or retiree of a participating employer in South Carolina, you can enroll in a health plan or an HMO and the dental plan within 31 days of the date you are hired or the date you retire. To enroll, you must complete the required forms, including a Notice of Election (NOE) form. Coverage is not automatic. You also can enroll your eligible dependents.

To participate in Dental Plus, you must be enrolled in the State Dental Plan, and you must have the same level of coverage—cover the same family members—under both plans.

After you enroll, please check your payroll stub to make sure the correct amount is being deducted. Your health and dental coverage will continue from one year to the next as long as you are a full-time, permanent employee or eligible retiree. Your coverage begins on the first day of the month if you are actively at work on the first working day of the month. Otherwise, it starts on the first day of the following month. Your enrolled dependents' coverage begins on the same day yours does.

Eligibility

An eligible active employee:
- Is employed by the state, a school district or a participating local subdivision
- Works in a permanent full-time position as defined in the plan and
- Receives compensation from a department, agency, board, commission or institution of the state, a school district or a participating local subdivision.

Eligible employees also include clerical and administrative employees of the S.C. General Assembly and judges in the state courts. S.C. General Assembly members and elected members of participating county or municipal councils, who also participate in the S.C. Retirement Systems (SCRS), are considered employees for insurance purposes. If you work for more than one participating employer, please contact your benefits administrator for further information. Permanent, part-time teachers are eligible for state health, dental, Dental Plus, MoneyPlu$ and vision care benefits.

Retirement eligibility is explained in detail in the Retirees chapter on page 135.

Transferring Employee

As an active employee, you are considered a transferring employee if you move from one state group employer to another with no break in coverage or if there is no more than a 15 calendar-day break in employment.

As an **academic employee**, you are considered a transfer if you complete a school term and move to another participating academic employer at the beginning of the next school term. Your insurance coverage remains in effect, even if you did not work during the summer. If you do not transfer to another covered employer, your coverage ends the last day of the month in which you were actively at work.

A transferring employee is not considered a new hire for insurance purposes. When you transfer, you must remain enrolled in all of the same insurance programs in which you were enrolled at your former employer.

When you leave your job, tell your benefits administrator that you are transferring from one state group employer to another. EIP will produce a transfer form that will be sent to the benefits administrator at your new employer.

Late Entry

If you do not enroll within 31 days of the date you begin employment or retirement, you cannot enroll yourself and your dependents until the next open enrollment period or within 31 days of a special eligibility situation. Open enrollment is held in odd-numbered years.

SPECIAL ELIGIBILITY SITUATIONS

A special eligibility situation is an event that allows eligible employees, retirees, survivors or COBRA subscribers to enroll themselves and/or their eligible dependents in an insurance plan. Examples include marriage, birth, adoption or placement for adoption. Involuntary loss of other coverage is a special eligibility situation only for those who lost coverage. You have 31 days from the date of the event to complete an NOE requesting a change in coverage. A salary increase is not a special eligibility situation.

Changing Plans or Coverage

You can change to or from the Savings Plan, the Standard Plan, a health maintenance organization (HMO) or the TRICARE Supplement only during October enrollment periods or within 31 days of a special eligibility situation. There may be exceptions to this rule. Contact your benefits administrator for details if you are an active employee or if you are a retiree, a survivor or COBRA subscriber of an optional employer. Retirees, survivors and COBRA subscribers of other employers should contact EIP.

Retirees and survivors and their eligible dependents who are enrolled in a health plan may change to the Medicare Supplemental Plan within 31 days of Medicare eligibility or during open enrollment, which is in October of odd-numbered years.

If you are enrolled in Medicare, you may not enroll in the Savings Plan or the TRICARE Supplement. Active employees of any age and retired employees who are not eligible for Medicare can enroll in the Savings Plan.

You can change your dental coverage only within 31 days of a special eligibility situation or during open enrollment, which is in October of odd-numbered years.

You will find detailed information about each year's enrollment options in *The Insurance Advantage*, which you will receive in mid-September.

Marriage

If you wish to add a dependent spouse and/or child because you marry, you can do so by completing an NOE within 31 days of the date of your marriage. Coverage becomes effective with the date of marriage. You cannot cover your spouse as a dependent if he is eligible, or becomes eligible, for coverage as an employee or as a retiree of a participating employer. (Exceptions may apply.) If you do not add him within 31 days of the date of marriage, you cannot add him until the next open enrollment period or within 31 days of a special eligibility situation.

Divorce

If you divorce, you must drop your spouse from your coverage by completing a Notice of Election (NOE) form within 31 days of the date the divorce decree is signed. Your divorced spouse's coverage ends the last day of the month in which the divorce decree is signed.

However, you may continue to provide health, dental and dependent life coverage for your former spouse and for your children who no longer live with you if the Family Court requires that you do so. Give a complete copy of the Family Court order, not just the section requiring the coverage, to your benefits administrator (BA) with your NOE. Your BA will send both to EIP. Retirees from state agencies, schools and institutions of higher education and COBRA subscribers should contact EIP.

You also can continue to cover your children if they live with you and you are financially responsible for them. In some cases, a court order to cover a dependent child or ex-spouse does not create a special eligibility situation for the employee, if the employee is not already enrolled. In these cases, the employee will need to wait until the next open enrollment period or until a special eligibility situation occurs to enroll himself and the dependent child or ex-spouse.

If you remarry, you can cover your divorced spouse or your current spouse, but you cannot cover both. Dependents who lose coverage due to a qualifying event may be eligible to continue coverage under COBRA. For more information, you must contact your BA or EIP as soon as possible but no later than within 60 days of the event or from when coverage would have been lost due to the event, whichever is later.

Adding Children

Eligible children may be added by completing an NOE within 31 days of the date of birth (notification to Medi-Call of the delivery of your baby does not add the baby to your health insurance), gaining custody, adoption or placement for adoption. Children must be listed on your NOE to be covered, even if you already have family coverage. If you and your spouse are both covered employees, only one of you can cover your children.

Full-time Students

You can cover your dependent children, ages 19-24, who are full-time students. They must meet these requirements:

- Students must be enrolled in and attending an accredited high school, vocational/trade school or college/university *full-time*, as defined by the institution they attend.
- While summer school is not required for maintaining student status, dependents who enroll in summer school full-time may become eligible. However, they will lose eligibility if they do not re-enroll full-time the next semester/quarter.
- Adult education night classes and correspondence courses do not constitute full-time attendance.

The TRICARE Supplement Plan has its own requirements for coverage of dependents age 19 and older. Please refer to page 61 for more information.

If you are an active employee, EIP will send a Student Certification letter to your benefits administrator about 90 days before your dependent's 19th birthday. To continue coverage, this form must be completed and returned to EIP within 31 days of the child's 19th birthday. Also include a statement on letterhead from the institution he is attending confirming that he is a full-time student. If the child's 19th birthday occurs during the summer, return the Student Certification letter to EIP with the "Pending Student Certification" block marked. You must submit a letter from the institution by September 30 verifying that your child is a full-time student.

If your dependent, age 19-24, goes back to school full-time, you may again add him to your health coverage. To do so, submit a Notice of Election (NOE) form and verification that he or she is a full-time student on letterhead from the institution, within 31 days of eligibility. In this case, that would be the date he is again a full-time student.

If your child is covered as a full-time student, his eligibility for coverage ends the last day of the month in which he graduates, is no longer a full-time student, marries or the last day of the month in which he turns age 25, unless he is covered as an incapacitated dependent. It will be your responsibility to notify your benefits office that the child is no longer a full-time student. If notification is received within 60 days of when coverage would have been lost due to the event, COBRA continuation of coverage will be offered. Otherwise, it will not.

EIP conducts periodic reviews of the eligibility of covered dependents ages 19-24. If your child is found to be ineligible, his coverage will be cancelled, and EIP may seek repayment of any benefits paid for him while he was ineligible.

If your child is **not** a full-time student, his eligibility for coverage ends the last day of the month in which he turns 19, unless he is covered as an incapacitated dependent. Your dependent child's eligibility for coverage also will end if he gets married or gets a job with benefits.

Incapacitated Child

You can continue to cover your child, who is age 19 or older, if he is incapacitated and you are financially responsible for him. To cover your dependent child who is incapacitated, he must meet these requirements:

- The child must be covered at the time of incapacitation.
- The child must be unmarried and must remain unmarried to continue eligibility.
- The child must be incapable of self-sustaining employment because of mental illness, retardation or physical disability and must remain principally dependent (more than 50 percent) on the covered employee, retiree, survivor or COBRA subscriber for support and maintenance.

Incapacitation must be established within 31 days of the child's 19th birthday or within 31 days of the date he is no longer a student. An Incapacitated Child Certification Form must be completed by the subscriber and the attending physician and then sent to EIP for review.

Gaining Other Coverage

If you or your dependents gain other group coverage, you have 31 days to change your coverage by completing an NOE and returning it to your benefits office with proof of the other coverage. If you fail to make a coverage change within 31 days, you must wait until the next open enrollment period. For more details, contact your benefits administrator or EIP.

Involuntary Loss of Other Coverage

If you or your dependents are covered under another health or dental plan and you lose that coverage involuntarily because it was discontinued or the covered employee left his or her job, you have 31 days from the last day of coverage to enroll in coverage offered through the EIP. To enroll, you must complete an NOE and return it to your benefits office with proof that the insurance was discontinued. Dependents must also be listed on the NOE in order to be covered, and the documentation of loss of coverage must indicate who was covered. Only family members who actually lost coverage may enroll. If you fail to enroll within the 31 days, you must wait to enroll until the next open enrollment, which occurs in October of odd-numbered years, or within 31 days of a special eligibility situation.

Leave Without Pay

If you are an active employee, you can continue your coverage for up to 12 months if you are on leave without pay, as long as you pay the required premiums. Leave must be approved by your employer or must be a result of injury or sickness. *(For information on Family and Medical Leave or military leave, contact your benefits administrator.)*

Medicare at 65

The Social Security Administration should notify you of your eligibility for Medicare about 90 days before you turn 65 or when you become eligible due to a disability. If you are not notified, contact your local Social Security office. If you are already receiving Social Security benefits when you turn 65, Medicare Part A starts automatically, and you should not turn down Part B. If you are not receiving Social Security, you should sign up for Medicare before your 65th birthday, even if you are not ready to retire. **You should not sign up for Medicare Part D, the prescription drug program. Your drug expenses will continue to be covered under the health insurance plan that you have through EIP.**

IMPORTANT MEDICARE NOTE:

If you or one of your dependents become eligible for Medicare, you must notify EIP within 31 days of Medicare eligibility. **If you do not notify EIP of your Medicare eligibility, and EIP continues to pay benefits as if it were your primary insurance,** when EIP discovers you are eligible for Medicare, EIP will:

- **Immediately begin paying benefits as if you were enrolled in Medicare**
- **Seek reimbursement for overpaid claims back to the date you or your dependent(s) became eligible for Medicare.**

If You Are an Active Employee When You Turn 65

If you are actively working and/or covered under a state health plan for active employees when you turn 65, you may delay enrollment in Part B because your insurance as an active employee remains primary while you are working. However, if you are planning to retire within three months of age 65, you should contact Social Security to learn about your Medicare enrollment options.

When you do retire, remember that you should sign up for Part B within 31 days of retirement. Medicare will then be your primary coverage, and you need Part A and Part B for full coverage. You should not turn down Medicare Part B coverage because the SHP will begin paying benefits as if you were enrolled in Part B. **Most Medicare recipients covered by health insurance plans offered through EIP should not sign up for Medicare Part D, the prescription drug program. Your drug expenses will continue to be covered under your health insurance.**

When Your Coverage Ends

Your coverage will end:

- The last day of the month in which you were actively at work, if you are not transferring to another covered employer
- The last day of the month you enter a class of employees not eligible for coverage (for example, your working hours are reduced from full-time to part-time)
- The day after your death
- The date the coverage ends for all employees or
- If you do not pay a required premium when it is due. (For example, if you are on leave without pay or on COBRA and are paying the full cost, you must make a monthly payment.)

What is a participating employer?

See page 207 for more information.

Dependent coverage will end:

- The date your coverage ends
- The date dependent coverage is no longer offered or
- The last day of the month your dependent is no longer eligible for coverage

If your coverage or your dependent's coverage ends, you may be eligible for continuation of coverage as a retiree or survivor or under COBRA. If you are dropping a dependent from your coverage, you must complete an NOE within 31 days of the date the dependent is no longer eligible for coverage.

COBRA

COBRA is short for the Consolidated Omnibus Budget Reconciliation Act. It requires continuation of group health and/or dental insurance coverage be offered to you and your covered dependents if you are no longer eligible for coverage due to a qualifying event.

You can continue your coverage for a limited time under COBRA if you and/or your covered dependents lose coverage because:

- The covered employee's working hours are reduced from full-time to part-time
- The covered employee voluntarily quits work, retires, is laid off or is fired (unless the firing is due to gross misconduct)
- The covered employee is separated or divorced from his spouse
- A child no longer qualifies as a dependent
- The covered employee or the parent of an eligible dependent child becomes eligible for Medicare

To qualify for continuation of coverage, you must notify your benefits office or EIP within 60 days of the date you become divorced or separated, the date your dependent child becomes ineligible for coverage or from the date coverage would have been lost if the event had been reported in a timely manner. Otherwise, your rights to continuation of coverage under COBRA will be forfeited.

To continue coverage under COBRA, you must complete and return an NOE to EIP within 60 days of the event or from when coverage would have been lost due to the event, whichever is later.

If you are enrolled in the TRICARE Supplement, continuation of health coverage is offered through Humana Military Healthcare Services, Inc. Please call 800-444-5445 for information. Dental coverage can be covered under EIP's COBRA plan if timely notification is made.

COBRA coverage becomes effective when the first premium is paid and remains in effect only as long as the premiums are kept up to date. If you need more information about COBRA, contact your benefits office or EIP.

Conversion: When COBRA Benefits Run Out

The Health Insurance Portability and Accountability Act of 1996 guarantees that persons, who have exhausted COBRA benefits and are not eligible for coverage under another group health plan, have access to health insurance coverage without being subject to a pre-existing condition exclusion period. However, certain conditions must be met. In South Carolina, the South Carolina Health Insurance Pool provides this guarantee of health insurance coverage. For information, call 800-868-2500, ext. 42757, or 803-788-0500, ext. 42757, in Columbia.

Death of an Employee or Retiree

If an active employee or retiree of a local subdivision dies, you as a surviving family member should contact the deceased's employer to report the death, end the employee's health and dental coverage and start survivor coverage (if applicable). If a state agency or school district retiree dies, you should contact EIP.

Survivors

Spouses or child(ren) of a covered deceased employee or funded retiree, who are covered as dependents under the State Health Plan or an HMO, are classified as "survivors." As survivors, they are eligible for a one-year waiver of health insurance premiums.

Participating optional employers (local subdivisions) may elect to, but are not required to, waive the premiums of survivors of retirees. If you are a retiree of a participating optional employer, check with your benefits administrator to see whether this waiver would apply.

After the first year, a survivor must pay the full premium to continue coverage. If you and your spouse are both covered employees or retirees at the time of death, the surviving spouse is not eligible for the premium waiver.

If you are a covered spouse or dependent child of a covered employee, who was killed in the line of duty while working for a participating employer, your premium will be waived for the first year after the employee's death. After the one-year waiver, you may continue coverage, *at the employer-funded rate*, as long as you are eligible. Participating optional employers may elect to, but are not required to, contribute to your insurance coverage, but you may continue coverage, at the full rate, for as long as you are eligible.

State Dental Plan and Dental Plus premiums are not waived. However, survivors can continue dental coverage by paying the full premium.

As a surviving spouse, you can continue coverage until you remarry. If you are a dependent child, you can continue coverage until you are no longer eligible as a dependent. If you are no longer eligible for coverage as a survivor, you may be eligible to continue coverage under COBRA. Contact EIP for details.

Workers' Compensation

Insurance offered through EIP is not meant to replace Workers' Compensation and does not affect any requirement for coverage for Workers' Compensation insurance. It is not intended to provide or duplicate benefits for work-related injuries that are within the Workers' Compensation Act. If you need more information, please contact your benefits office or EIP.

Coordination of Benefits

Some families, particularly those in which both the husband and wife work outside the home, are eligible to enroll in two health plans. While the additional coverage may mean that more of your medical expenses are paid by insurance, you probably will pay premiums for both plans. Weigh the advantages and disadvantages carefully before you purchase extra coverage.

Most health plans have a system to determine how claims are handled when a person is covered under more than one insurance plan. This is called "coordination of benefits" (COB). When a subscriber has coverage under more than one plan, he can file a claim for reimbursement from each plan. Plan administrators, such as BlueCross BlueShield of South Carolina or your HMO, coordinate benefits so that you get the maximum reimbursement allowed. That amount will never be more than 100 percent of your covered medical, dental or prescription drug expenses.

There are rules that determine the order in which the plans pay benefits. The plan that pays first is the *primary* plan. The *secondary* plan pays after the primary plan. Here are some examples of how that works:

- The plan that covers a person as an employee is primary to the plan that covers the person as a dependent.
- When both parents cover a dependent child, the plan of the parent whose birthday comes earlier in the year is primary.
- If you are eligible for Medicare and are covered as an active employee, your State Health Plan or HMO coverage is primary over Medicare. Exceptions may apply in the case of Medicare coverage due to kidney disease. Contact your local Social Security office for details.

For more information about how coordination of benefits works:

- The Standard Plan and the Savings Plan – page 25
- The State Dental Plan and Dental Plus – page 70
- MUSC Options – page 56

Prevention Partners

Prevention Partners, a unit of the Employee Insurance Program, is designed to help you and your family lead healthier lives. Its activities, programs and services promote good health through disease prevention, early detection of disease and chronic disease education.

A major initiative of Prevention Partners is the Preventive Worksite Screening. This comprehensive health screening measures cholesterol levels, blood pressure, triglyceride levels, kidney function and red and white blood cell counts. These measurements indicate if an employee is at risk for developing hypertension, diabetes and anemia.

This benefit is available for $15 to subscribers whose primary coverage is the Standard Plan, the Savings Plan, BlueChoice HealthPlan, CIGNA HMO or MUSC Options. Retiree subscribers are eligible if the State Health Plan is their primary insurance coverage. Those covered by Medicare or the TRICARE Supplement are not eligible.

The cost of the Preventive Worksite Screening does not contribute toward your annual deductible or out-of-pocket maximum.

Chronic Disease Workshops, another major program, give subscribers information they need to help them take better care of themselves. Workshops include: Caregivers, Diabetes, Heath Disease, Asthma, Kidney Evaluation, Women's Reproductive Health, Weight Management, Medications, Men's Health, Cholesterol/Lipids and Gastrointestinal Ailments.

In 2002 the Budget and Control Board's Office of Research and Statistics compared 196 State Health Plan subscribers who attended a Diabetes Management Workshop between 1995 and 1999 with a group of subscribers who did not. During a two-year period, the medical and drug claims of the group that attended the workshop were $2,123.99 less than those who did not. The study indicates participants in the workshop were doing a better job controlling the risks of complications of their disease.

Other Prevention Partners programs include:
- Spring Wellness Walk
- Lifestyle change workshops on lowering risk factors, weight loss and exercise
- Worksite program consultation
- Volunteer Worksite Prevention Partners coordinator network and conferences
- Prevention Partners training workshops
- Preventive Worksite Immunization (influenza)

For more information on Prevention Partners, contact your benefits office, your Prevention Partners coordinator or call 803-737-3820 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area). You also can go to the EIP Web site at www.eip.sc.gov.

THE VISION CARE PROGRAM

This program offers you discounted vision care services. Participating ophthalmologists and optometrists throughout the state have agreed to charge no more than $60[1] for a routine, comprehensive eye examination. If you are fitted for contact lenses, you may pay more because that can require additional services. Participating providers, who include opticians, have agreed to give a 20-percent[1] discount on all eyewear except disposable contact lenses.

[1]These amounts can change yearly. Contact your benefits office, provider or EIP for the current amounts.

If you are covered by more than one vision care program, you can have the discounts offered under this program or through your other coverage, but not both.

The eye examination should include at least these tests and services:
- Complete eye and medical history review
- Visual acuity far and near, with and without glasses
- Tonometry
- Screening visual fields
- Refraction
- External motility, biomicroscopic and dilated

Looking for a provider who participates in your network? Just log on to the EIP Web site at www.eip.sc.gov, choose your category and click on "Online Directories."

- Ophthalmoscopic examinations
- Initiation of diagnostic and treatment programs as necessary, including prescription of lenses, medication and other therapy, arranging for special diagnostics or treatment services, consultations, laboratory procedures or radiological services as may be indicated.

Treatment must be within the scope of the license of the provider. Consult your eye care provider for details on any of these services.

You may participate in this program if you are a full-time or part-time employee, retiree, survivor or COBRA participant. Your dependents also are eligible. You do not have to be enrolled in the State Health Plan or a health maintenance organization. It is your responsibility to show your provider some type of employment-related identification to prove you are eligible for the Vision Care Program. If you don't, you may not receive the discount.

Providers Are Available Statewide

To see the list of participating providers, go to the Employee Insurance Program's Web page, www.eip.sc.gov. Click on "Choose Your Category" and then select your category (active subscriber, retiree, etc.). Next, choose the "Online Directories" button and then select "Vision Care." You can search for providers by county or by state. **This list is updated regularly and is the most current one available.**

If your provider is not listed, you may wish to call and ask if he gives discounts through the state's Vision Care Program. Although the directory lists providers who participate in the program, the state does not recommend any specific eye care provider.

If you need a paper copy of the directory, you may request one from your benefits administrator or from EIP (P.O. Box 11661, Columbia, SC 29211, or by calling 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Greater Columbia area).

No Claims to File

The Vision Care Program is a discount program. You do not file claims and will not receive reimbursement for routine eye examinations or eyewear, including contacts. If you have a MoneyPlu$ Medical Spending Account, you can file a reimbursement claim with MoneyPlu$ for your vision care expenses.

If you have questions about this program, please contact your benefits office or EIP.